b. **Report Deadline.** The report must be filed by September 1 of each year. Extensions of not more than 30 days may be granted on a showing of just cause.

c. **Accounting Principles.** The report must be prepared on the basis of generally accepted accounting principles and the accrual basis of accounting, except as otherwise specified in the cost report instructions.

d. **Signature.** The cost report shall be signed by an owner, partner or corporate officer of the NF, by an officer of the company that manages the NF, and by the person who prepared the report.

e. **Audits of Cost Reports.** The Authority will conduct a desk review to verify the completeness and mathematical accuracy of all totals and extensions in each cost report. Census information may be independently verified through other OHCA sources. In addition, a sample number of cost reports will be audited independently by an auditor retained by OHCA. Any NF that is subject to an audit is required to make its records available to OHCA and to any auditor engaged by OHCA.

2. **ALLOWABLE AND UNALLOWABLE COSTS**

Only "allowable costs" may be included in the cost reports. (Costs should be net of any offsets or credits.) Allowable costs include all items of Medicaid-covered expense that NFs incur in the provision of routine (i.e., non-ancillary) services. "Routine services include, but are not limited to, regular room, dietary and nursing services, minor medical and surgical supplies, over-the-counter medications, transportation, and the use and maintenance of equipment and facilities essential to the provision of routine care. Allowable costs must be considered reasonable, necessary and proper, and shall include only those costs that are considered allowable for Medicare purposes and that are consistent with federal Medicaid requirements. (The guidelines for allowable costs in the Medicare program are set forth in the Medicare Provider Reimbursement Manual ("PRM"), HCFA-Pub. 15.) Ancillary items reimbursed outside the NF rate should not be included in the NF cost report and are not allowable costs. Quality of Care assessment fees are allowable costs for reporting purposes.

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3. COMPUTATION OF THE STATEWIDE FACILITY BASE RATE

Cost reports used to calculate the rate were those filed for the year ended June 30, 1999. ("base year"). A state plan will be submitted when costs are rebased. A description of the calculation of the base per diem rates for the periods beginning September 01, 2000, October 01, 2000, and December 01, 2000 are as follows:

A. Primary Operating Costs

1. Determine the weighted mean primary operating per diem by summing all reported primary operating expenses of all nursing facilities serving adults (excluding facilities serving only AIDS patients) and dividing by total period patient days. Primary operating costs consists of all non-capital costs excluding administrative services, which are described on page 4.

2. Determine the audit adjustment per diem to be extrapolated to all reporting facilities based on desk reviews and independent sample audit findings. The audit adjustment is based on an average of the difference between reported and audited cost reports for field audited facilities. If no audit file is available, an average audit adjustment will be determined from the average audit adjustments from the previous 5 years available.

3. Determine the adjusted primary operating per diem by subtracting the audit adjustment per diem (step 2) from the weighted mean primary operating costs per diem determined in step 1.

4. Trend forward the adjusted primary operating per diem from the midpoint of the base year to the midpoint of the rate period state fiscal year using the inflation update factors. The Authority will use the update factors published in the Data Resources, Inc., ("DRI") nursing home without capital marketbasket index for the fourth calendar quarter of the previous fiscal year.

   For example, for the rates effective July 1, 1997, the Authority used the update factors for the fourth quarter of calendar year 1996.

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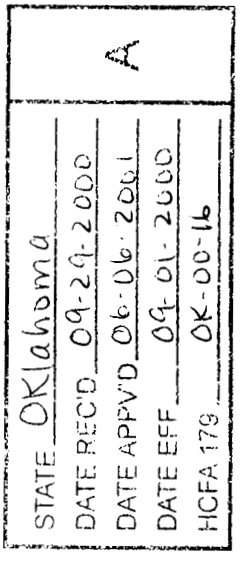
B. Administrative Services

An imputed administrative services allowance will be used in lieu of actual owner/administrator salary and non-salary compensation. The imputed administrative services allowance is the state-established limit or value for the purposes of calculating the reimbursement rate.

The base allowance will be the same as that determined for the regular Nursing facilities in 3.B on pages 3 and 4. The allowance will be trended forward in the same manner as in 3.A.4 on page 3.

C. Capital

An imputed allowance will be used in lieu of actual depreciation, interest, and lease related to facilities and equipment. The imputed allowance is determined by dividing the total reported costs (from the base year cost reports) for the regular nursing facilities, plus that for the regular nursing facilities serving aids patients, plus that for the private standard intermediate care facilities for the mentally retarded plus that for the private specialized (16 bed or less) M/R facilities by the total "adjusted days" for those facilities. The "adjusted" days are determined by multiplying the allowable days from the base year cost report by a factor of .93 (i.e. adjust to a 93% occupancy level). To account for inflation this imputed capital allowance will be trended forward to the rate period state fiscal year by the Marshall-Swift replacement cost multipliers for facilities with Class C construction (District Comparative Cost Multipliers, Central Region) published in the January index of the year preceding the rate change period.



D. Adjustment For Change In Law Or Regulation

The Authority also considers possible effects on rate year costs compared to base year costs that might not be fully accounted for by the DRI index described above. Inasmuch as the index is an estimate of actual and forecasted national rates of change in the price of nursing home goods and services, DRI is not specific to any state. Thus during a given period, it might not sufficiently account for the economic effects of changes in federal laws or regulations which have a disparate impact on Oklahoma, or of changes in state laws, rules or circumstances that only affect Oklahoma.

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The following circumstances may cause an adjustment to rate year costs: additional costs incurred to meet new requirements imposed by government regulatory agencies, taxation, authorities, or applicable law (e.g., minimum staffing requirements, social security taxation of 501(c) (3) corporations, minimum wage change, etc.) and implementation of federal or state court orders and settlement agreements.

OHCA will evaluate available financial or statistical information, including data submitted on cost reports and special surveys to calculate any base rate adjustment. These adjustments will become permanent until such time a state plan amendment is submitted to rebase the rates.

Per HB 2019, the Oklahoma 2001 Health Care initiative, the following adjustments will be made.

1. For the rate period beginning September 1, 2000 the OHCA has calculated an Oklahoma Specific additional cost of expected increase in Liability insurance rates. The rate will be adjusted by an additional $.51 for the expected cost. The amount of additional cost was determined from a sample of nursing facility invoices from the 1999 and 2000 fiscal years and from data from the base year cost reports. The total sample costs for 1999 were compared to the total sample costs for 2000 to get an overall percent of increase. Total available days from the base year cost report was divided by 365 to estimate the number of beds which in turn was multiplied by an estimated annual cost of $100 per bed (per industry survey) to get an annual estimate for the rate year period. The resulting cost was divided by the total patient days from the base year cost reports and multiplied by the percent increase from above to determine the added cost per day.

   This add-on will be trended forward by the same method as in 3.A.4 on page 3.

2. For the rate period beginning September 1, 2000 the OHCA has calculated the additional cost of new direct care staffing requirements. These new requirements are to maintain staff-to-

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patient ratios of 1:8, 1:12 and 1:17 for the three 8 hours shifts for day, evening and night, usually beginning at 8:00 a.m., 4:00 p.m. and 12:00 a.m., respectively. The rate will be adjusted the cost of maintaining a level of staffing that is at 86.5% of the base year level above the minimum requirement.

This adjustment is calculated as follows:

1. Determine the direct care hours per day from the base year cost report data for all private facility types.
2. Determine the direct care cost per day (including benefits) of the hours determined in 1 from the base year cost reports.
3. Adjust the hours per day for the effect of the minimum wage requirement of HB 2019 by multiplying the factor determined in 2 by the percent of the cost of the minimum wage increase to the total salaries and benefits in the base period.
4. Determine the amount of hours per day in the base period that actual direct care hours exceeds the minimum requirement.
5. Apply a factor of .865 (86.5%) to the amount determined in 4. This is the estimated amount that the facilities will remain above the minimum required hours.
6. Add the amount determined in 5 to the amount of new required minimum hours per day to get the expected level of hours per day for the rate period. Divide the expected level of hours by the level of hours in the base year to get a percent increase.
7. The cost per day is determined by multiplying the percent in 6 by the cost in 3 to get the add-on. For the period beginning 09-01-00 this amount is $2.22.

The direct care staff-to-patient ratios required and the employees to be included in the ratios are defined in Section1-1925.2 of Title 63 of the Oklahoma Statutes. In general, direct care staff includes any nursing or therapy staff providing hands-on care. Prior to Sept. 1, 2002 Activity and Social Work staff not providing hands-on care are allowable. On Sept. 1, 2002 Activity and Social Work staff not providing hands-on care shall not be included in the direct care staff-to-patient ratios. The direct care staff-to-patient ratios will be monitored by the Authority through required monthly Quality of Care Reports. These reports and rules may be found in

the Oklahoma Administrative Code at OAC 317:30-5-131.2. This section of the Code also includes rules for penalties for non-timely filing and the methods of collection of such penalties. Non compliance with the required staff-to-patient ratios will be forwarded to the Oklahoma State Department of Health who in turn under Title 63 Section 1-1912 through 1-1917 of the Oklahoma Statutes (and through the Oklahoma Administrative Act Code at 310:675) will determine "willful" non-compliance. The Health Department will inform the Authority as to any penalties to collect by methods noted in OAC 317:30-5-131.2. This add-on will be trended forward by the same method as in 3.A.4 on page 3.

3. HB 2019 requires that all licensed nursing facilities pay a statewide average per patient day Quality of Care assessment fee based on 6% of the average gross revenue per patient day. An estimate of the Calendar 1999 surveys reporting this data was used to set the rate for the period beginning September 1, 2000. This estimate and rate adjustment will be $4.00 per day. The estimate was determined by multiplying the SFY 1999 rate for regular nursing homes by 6% (.06 x $66.75). The OHCA was also directed to collect the assessment, assess penalties for late payment and deposit the assessments into a "Quality of Care Fund" and make payments from said fund for the purposes listed in the Bill.

The actual rate for the period beginning 09-01-00 will be determined from calendar 1999 surveys at a later date. When received, an adjusted rate will be established that reimburses the facilities for the estimated actual costs to be incurred during the rate period state fiscal year. Gross revenues are defined as Gross Receipts (i.e. total cash receipts less donations and contributions). For subsequent state fiscal years the per day assessment fee will be determined in advance from the totals of the monthly Quality of Care Reports, Section C, for the 6 month period from October 1 through March 31 of the prior fiscal year, annualizing those figures and determining the fee by dividing the total revenues by the total days and taking that result and multiplying by .06 (6%).

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4. For the rate period beginning October 1, 2000 an adjustment of $3.00 per day will be added to the rate for the estimated cost of a minimum wage for specified salaries as mandated by HB 2019. The minimum wage will be $6.65 per day for the following specified positions: Registered nurse, Licensed practical nurse, Nurse aides, Certified medication aides, Dietary staff, Housekeeping staff, Maintenance staff, Laundry staff, Social service staff, and other activities staff. The OHCA will monitor this requirement and assess penalties as discussed in 2 above.

   The adjustment is determined as follows:

   1. Determine the number of hours reported on the base year (SFY 1999) cost reports for those employee classes at an average salary of less than $7.00 per hour.
   2. Determine the number of hours reported on the base year cost reports for those classes at an average salary of $7.00 to $10.00 per hour.
   3. Determine the period add-on for benefits by dividing the base year cost report total benefits by total salaries.
   4. Determine the direct effect class add-on by multiplying 20% of the hours determined in 1 by the rate of increase in the minimum wage (including benefits which means the rate of increase plus the percent add-on determined in 3).
   5. Determine the ripple effect class add-on by adding the hours in 1 and 2 and subtracting the hours determined in 4. 35% of this total is multiplied by the rate of increase in the minimum wage plus benefits (see above).
   6. Determine the total add-on by totaling the results in 4 and 5.

   This add-on will be trended forward by the same method as in 3.A.4 on page 3.

5. For the rate period beginning December 1, 2000 the provider assessment fee set at September 1, 2000 will be adjusted to compensate for the actual fee determined by the surveys of data received. The rate adjustment needed for this increased cost is $1.29. Surveys were sent to the nursing facilities collecting revenue and patient day data for calendar 1999. Per HB2019 this

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data was to be used to set provider fee assessment rates for the different facility types. The assessment fee for the period beginning 09-01-00 was set at $4.90. This adjustment is needed for the remainder of the state fiscal year to appropriately reflect the actual costs and adjust for the estimated assessment reimbursement portion of the rate set at 09-01-00 (see D.3 above). The adjustment needed was determined by multiplying the difference between the estimated assessment in the rates at 09-01 and the actual assessments from the surveys by the total months that a difference occurred and dividing this total by the estimated days remaining in the rate period. After the initial rate period these adjustments will be amended to an annual basis.

6. HB 2019 directed the Nursing Facilities to provide for dentures, eyeglasses and non-emergency transportation attendants for Medicaid clients in nursing facilities. For the rate period beginning December 1, 2000 the rate adjustment for the estimated cost of these added items of coverage is $2.45 per day. The costs were determined as follows:

   For the transportation travel attendant the base year cost report average hourly cost for a social worker was brought forward to the rate state fiscal year and an adjustment made for the effects of minimum wage and benefits. The cost of two FTE's per 100 bed home were determined by multiplying that total by 2080. From the cost report data percent of occupancy it was estimated that this 100 bed home would have 29,000 patient days which when divided into the cost of the two FTE's gives an add-on of $1.78 per day.

   For the cost of dentures it was estimated that 50% of the 25,000 Medicaid clients need eyeglasses once every three years. That correlates to an average of 4,165 services per year. The cost of those services was estimated at the Medicaid rates for one upper or lower one re-base and one reline (codes D5130, D5214, D5720 and D5751), or $567.47. This cost times the number of services divided by the estimated Medicaid patient days is the add-on needed for these services.

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For the cost of eyeglasses the total number of services needed is 75% of the 25,000 total population of Medicaid patients. It is estimated that 80% of those need services, or 15,000. The average cost per service was determined to be the total for one lens plus one frame plus one exam (codes W0105 to 0109,V2020 and 92002/92012). This total average cost per service is multiplied by the estimated total services per year and divided by the total estimated Medicaid days to get the per diem add-on.

This add-on will be trended forward by the same method as in 3.A.4 on page 3.

7. For the rate period beginning December 1, 2000 the OHCA has added $3.11 to the rate to cover the cost of staffing requirements of HB 2019 not covered in the rate change in 2 above. OHCA adjusted the rate by an additional $3.11 to cover the cost of maintaining the same level above the minimum requirements as in previous reporting periods and to adjust for the loss of the "Major Fraction Thereof" provision in determining compliance. The adjustment is determined as follows:

   1. The additional hours needed to cover the loss of the "major fraction thereof" provision in meeting the minimum staffing requirements was determined by arraying the required hours for levels of patients from 60 to 99 under the new staffing requirements with the provision and without the provision. The average percent change in required hours was determined.
   2. The percent in 1 above was increased by another 25 percent to account for the loss of the three months (from 09-01-00) that this loss was not included in the rate adjustments (3 months divided by 12 months equals .25).
   3. The percent calculated in 2 above was added to 100% to also cover the level of staffing over the minimum that occurred in the base year. This percent was used in the method in D.2

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above to calculate the per day amount required to fund both the loss of the "major fraction thereof" and funding at the same level above the minimum requirement that occurred in the base year.

4. The add-on at 09-01-00, calculated in D.2 above was subtracted from the per day amount determined in 3 above to determine the add-on required for 12-01-00.

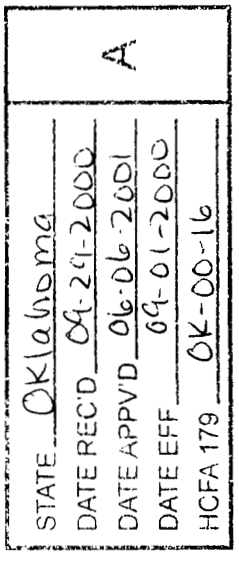
   This add-on will be trended forward by the same method as in 3.A.4 on page 3.

E. Statewide Base Rate

The statewide facility base rate is the sum of the primary operating per diem, the administrative services per diem, the capital per diem and the adjustments for changes in law or regulation less the enhancement in 4 below.

4. **Enhancements**

The Authority may further adjust the statewide facility base rate to include estimates of the cost of enhancements in services that are not otherwise required by law but which the Authority wishes to recommend as the basis for inclusion in the NF rates.



Effective May 1, 1997 the State will pay an interim adjustment of $3.15 per diem for specified staff to facilities who have elected to participate in the wage enhancement program.

Allowable costs include the salaries and fringe benefits for the following classifications: licensed practical nurses (LPNs), nurse aides (NAs), certified medication aides (CMAs), social service director (SSDs), other social service staff (OSSS), activities directors (ADs), other activities staff (OAS), and therapy aid assistants (TAA). These classifications do not include contract staff.

A settlement will be made based on the variance in the amount of enhanced payments and the amount expended for wages and benefits paid for the specified staff. The settlement will be capped at $3.15 per day.

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Facility-specific target rates were determined for each provider. Fiscal year 1995 costs were used to set the rates. The target rates were calculated as follows:

1. The reported salaries and wages for the specified staff were summed for each facility (specified staff salaries).
2. An employee benefits ratio was determined by dividing total facility benefits by total facility salaries and wages.
3. Total specified staff salaries were multiplied by the employee benefits ratio calculated in 2 above, to determine allowable employee benefits.
4. Specified staff salaries and allowable employee benefits were summed and divided by total facility patient days to arrive at the base year allowable cost per diem.
5. The base year allowable cost per diem for each facility was trended forward by factors of 2.9 percent and 3.1 percent.
6. An adjustment of $3.15 per day was added to the trended base year costs to arrive at the target rate for each facility.
7. For facilities demonstrating compliance for two consecutive quarters as of June 30, 2000, the reporting requirement is waived. Facilities not in compliance or not participating at July 1, 2000 may not participate in the program and receive the enhanced rate adjustment of $3.15. New facilities and facilities under new ownership may participate in the wage enhancement program and will be subject to the compliance requirements of the program.

COSTS OF COMPLIANCE WITH OMNIBUS BUDGET RECONCILIATION ACT (OBRA) OF 1987

All of the costs of compliance appear in provider cost reports used to develop rates. Therefore, no further adjustment or add-on is required.

RATE ADJUSTMENTS BETWEEN REBASING PERIODS

A. Beginning January 1, 2001 the rates will be adjusted annually on January 1, in an amount equal to the estimated savings or loss to the program as a result of the automatic cost of living adjustment on Social Security benefits as published in the Federal Register and the

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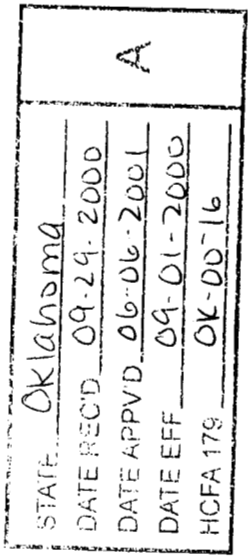
resulting effect to the spenddown required of the recipients. The rate adjustment will be determined as follows: the most recent calendar year (CY) total spenddown for Medicaid clients determined from the MMIS (Medicaid Management Information System), will be adjusted to the rate period (CY) by the Social Security Cost of Living increases as published in the Federal Register. The resulting spenddown estimate will be divided by the most recent available SFY total Medicaid days from the MMIS to determine the rate adjustment.



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STANDARD NURSING FACILITY SERVING VENILATOR – DEPENDENT PATIENTS

A statewide enhanced reimbursement rate shall be computed annually for nursing facilities (NFs) serving ventilator-dependent patients.

Definitions – Reimbursement is limited to the average standard rate paid to NFs serving adults plus an enhancement for ventilator patients. The enhanced payment is an amount reflecting the additional costs of meeting the specialized care needs of ventilator-dependent patients. To qualify for the enhanced payment, a facility must (1) not have a waiver under Section 1919(b)(4)(C)(ii) of the Social Security Act, and (2) submit a treatment plan and most recent doctor's orders and/or hospital discharge summary to the Oklahoma Health Care Authority for prior authorization.

Rate Determination – The add-on rate is determined prospectively as follows:

1. The estimated cost of direct care personnel is calculated using ventilator care-related criteria developed by the State of Minnesota. The criteria identifies the tasks, caregiver time estimate (in minutes per day) and caregivers (RN, LPN, etc.) required to complete each element of care on a daily basis. (For blood gas tasks, a respiratory therapist was substituted for the RN).

2. Each care giver time estimate, within each task category, is added together to arrive at a total caregiver time estimate within each task category. The total caregiver time estimate is converted to hours per day. It is then multiplied by a projected hourly wage rate by class of caregiver to arrive at a cost per day for each caregiver within each task category. Each cost per day for each caregiver is added together to arrive at a total caregiver cost within each task category. Each total caregiver cost is added together to arrive at a total caregiver cost to complete all identified tasks. The projected hourly wage rates were derived from the most recently available NF cost reports.

3. A factor for fringe benefits is calculated by dividing total employee benefits by total salaries and wages. The total caregiver cost to complete all identified tasks is multiplied by the factor for fringe benefits to arrive at a fringe benefit cost. The fringe benefit cost is added back into the total caregiver cost to complete all identified tasks to arrive at an adjusted total caregiver cost. Total employee benefits and total salaries and wages was derived from the most recently available NF cost reports.

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4. Based on provider input, and other survey information, the estimated average hours of specialized care required by ventilator-dependent patients was 9 hours per day. Each caregiver time estimate within each task category was added together to arrive at a total time estimate to complete all identified tasks, which was 13.69 hours. The adjusted total caregiver cost is multiplied by the ratio of 9 hours divided by 13.69 hours to arrive at a specialized caregiver cost.

5. The total patient care cost from the most recently available NF cost reports was calculated. The total patient care costs include nursing personnel including nursing employee benefits, medical director including employee benefits, social and ancillary service personnel including employee benefits, contract nursing, other contract personnel, medical equipment, dietary, drugs and medical supplies.

6. The difference between 24 hours and the estimated average hours of specialized care required by ventilator-dependent patients (9 hours) is divided by 24 hours. It is then multiplied by the total patient care cost which is then added to the specialized caregiver cost to arrive at the total 24 hour cost of patient care.

7. Five percent of the total patient care cost will be allowed for the additional cost of medical supplies not reimbursed by Medicare. A $4.00 per day adjustment will be allowed for nutritional therapy. Both additional costs are added back into the total 24 hour cost of patient care.

8. The difference between the total 24 hour cost of patient care (step 6) and the total patient care cost (step 5) is the add-on for ventilator patients.

9. The add-on for ventilator patients was inflated to the midpoint of the rate year using the fourth quarter publication of the Data Resources Inc., (DRI) Nursing Facility Marketbsket Index's forecast.

Cost Report Requirements – Uniform cost reports will be required of each nursing facilities and the State will provide for periodic audits of such reports. Facilities will be required to submit a separate cost report for ventilator care.

Adjustments – The add-on rate will be inflated when standard NF rates are changed by the fourth quarter publication of the Data Resources Inc., (DRI) Nursing Facility Marketbasket Index's forecast to the midpoint of the State Fiscal Year of the rate change.

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The add-on rate will be established prospectively according to the methods described above until a reimbursement rate can be derived from the cost reports which will reasonably reimburse the cost of an economic and efficient provider for ventilator patient care.

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